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REPORT OF PROF. FERDINAND HEBRA'S LECTURES ON VARIOLA,
DELIVERED AT THE GENERAL HOSPITAL AT VIENNA.

[Translated from the *Allgemeine Wiener Zeitung*, for the Boston Med. and Surg. Journal.]

BY E. JOY JEFFRIES, M.D.

VARIOLA is a disease which has been known from the earliest ages. In the very oldest writings we read of smallpox epidemics. Few diseases have swept away such numbers of the human race as this. When it began, amongst what people it originated, and how it spread itself abroad, can hardly now be determined, since the historical accounts vary greatly from each other, and are full of discrepancies. In accordance with a wide-spread opinion, smallpox is divided by some into two, by others into three *species*—variola vera, variola modificata (varioid) and varicella. But to support this view it must be first proved that there is more than one variola virus. Now the whole history of the disease before the introduction of vaccination, as well as since, shows that there never have been two forms of variola contagion, and that the mode of viewing the subject which induced this subdivision is an idea taken up *since* the introduction of vaccination.

It is a matter of interest for us, who live at a time and in countries where we come in contact with few people who have not been vaccinated, to investigate the action of smallpox before vaccination was used. Now if we consult the accounts of this disease, we shall find that it has showed itself in very different degrees of intensity, and that some epidemics have been particularly characterized by their violence and malignancy, a large proportion of those then attacked falling victims to it. Other epidemics again were not so dangerous, and their devastation much less. The fact that not every one attacked with smallpox exhibited the consequences of the disease, or bore its disfiguring scars, is a proof that there were then light cases of variola. Nevertheless there is nowhere among the old writers mention of a division into variola vera, variola modificata and varicella. These terms came much more into use after the introduction of vaccination, suggest-

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ed by the alterations in the disease when appearing in persons who had been vaccinated. These alterations we will now examine more closely.

More than a hundred years ago, before the cowpox vaccination was discovered, people endeavored, by the direct transmission of the human variola, to guard against this disease, which was so rapidly spreading by the ever-increasing traffic of man. Experience had taught that the malady, when not epidemic, was often very mild. They would not, therefore, expose a person to chance, and proceeded on the supposition that a mild form of the disease, not dangerous, could be produced by inoculating with the virus of a less intense variola, avoiding thereby the severe attack which was to be feared from accidental infection. Hence we deduce that there were *then* light cases, varicella and not a variola being used for inoculation. This means of protection was introduced (1718) into England by Lady Montague, wife of the English Ambassador in Constantinople. From thence it was soon after carried into other countries of Europe. The inoculation of the human smallpox consequently prevailed pretty generally. It is alleged to have been previously used for many centuries in Asia. There was, in fact, something in it, and the first experiments appeared to support it. But opportunity being soon given to show the sad results of this method, it fell into great discredit. Numerous cases occurred where a person inoculated from a varicella had an intense variola. It even happened that these inoculations *produced* epidemics, which promoted the further spreading of the smallpox, and it was soon forbidden by law, by most governments, and also here in Austria, where, however, as it was first allowed only on the "flat lands," its farther introduction was less to be cared for than in cities.

We have introduced these facts in order to prove that even previous to the use of vaccination, the smallpox was long known in its different degrees of intensity without leading to the division into species, such as variola, variolis and varicella, and regarding these as *different* exanthemata. It is entirely incorrect to make these distinctions, and as fallacious to wish to adduce historical proof of such a supposition. For example, Fuchs endeavors, with a waste of erudition, to prove that the variola modificata is older than the variola vera, that the pest of Thucydides was nothing else than a variola modificata, that the variola vera first came to us during the times of the Crusades, and that the varicella was a disease occurring simultaneously with this or that epidemic. The best proof that we can now-a-days adduce of the identity of the variola vera, modificata and varicella, is the establishment of the fact that they all owe their origin to one and the same contagion. Now this is plainly shown by the virus from a patient having variola vera, when it affects many persons, causing in one a lighter, and in another a severer form of the disease. And also of several

affected from a varicella, some will have variola vera, others varicella, according to their *individual receptibility*. Although such an experiment would not be purposely attempted, yet it often enough accidentally so occurs in life. For example, in clinics, where the different forms of the disease are developed in the students infected from a case of variola. And we cannot ascribe these differences to the varying intensity of the contagion, for even a furious and fatal variola hæmorrhagica can produce in others a varicella. This occurred a short time since with two sisters, one of whom died within a few days of variola hæmorrhagica, whilst the other escaped with a simple varicella.

In short, our statement above given is an irrefutable fact, supported by hundreds of cases. And we cannot impute the variety of these forms to vaccination. For instance, a child will be brought into the world having smallpox, and only some ten pustules can be found on the whole body. The child may be as fresh and vigorous as though not in the least sick. Shall we call this a variola vera because the child had not been vaccinated? We see a smallpox that hardly deserves the name occurring often enough in persons not vaccinated, whilst others who have been vaccinated and re-vaccinated fall victims to very severe variola. Nevertheless, it is a fact that vaccination has a most decided influence upon the form of the variolous process. Lately, at the request of the English Government, the question of vaccination was mooted; and Prof. Hebra proved by the statistical results of the smallpox wards, taken during a term of twenty years, not only that the number of vaccinated persons who took the smallpox was relatively less, but that these much oftener escaped with varicella. The mortality, moreover, was not more than five or six per cent., whilst with the non-vaccinated variola vera prevailed, and the mortality rose to thirty per cent. We shall return to this point in speaking of vaccination.

When, therefore, we speak of a variola vera, variola modificata, and varicella, they must be considered to stand in the same relation to each other as three different degrees of intensity of the same disease. It has not seemed to occur to any one that we might employ an analogous nomenclature in other diseases. We could, for instance, speak of a syphilis vera, modificata, and a syphilicella. In treating of measles and scarlatina, we have seen something similar, namely, that these exanthemata exhibited sometimes a copious, and sometimes a scanty or partial eruption, without our feeling forced to base a difference of species upon this fact. It must, however, be granted that with the smallpox there is more ground for making such a division, because there are notable differences to be seen in respect to the duration and issue of the disease.

The smaller the number of pustules, the shorter and less dangerous is, *cæteris paribus*, the attack. The greater their number,

the longer and severer it is. Long ago, such a form as ended favorably was called varicella, or innoxious pox, in contradistinction to variola vera, or malignant pox, which ended unfavorably. Since experience has taught that the danger increases with the number of the pustules, we can in the beginning of the disease use this as a standard by which to determine the severity of the case, when no other symptom can be depended upon. The duration of the diseased action is generally also proportional to the number of the pustules. And this can with better right be made the ground of subdivision, because there are cases where the disease is comparatively mild, and of short duration, notwithstanding the presence of numerous pustules, the latter being only superficial and their contents drying quickly. The duration of the disease, which we may express in numbers, will then afford us useful and pretty well-defined data for the different forms in which it appears. The most favorable cases, with the smallest number of pustules, i. e., varicella, lasts from the time of falling sick to the period of decrustation, at the farthest, fourteen days. The severe form, variola vera, has an average duration of four weeks, and over, if we do not take into account the accompanying metastatic processes. To all degrees between these two, i. e., where the desiccation occurs within three weeks, the name of variola modificata or variolis is given.

COURSE.—1. In the *stadium prodromorum* there are no sufficient characteristics by which to distinguish with certainty the species of disease present, and still less to determine the individual form of smallpox. The symptoms of fever do not present any peculiarities different from the other acute exanthemata, or at the most differ in the greater *severity* of the phenomena; in children, for instance. It cannot, however, be denied that the fever is sometimes quite inconsiderable. Passing to the accompanying symptoms, we must notice, because it is characteristic, the pain which many patients at first complain of in the limbs, along the spine, and especially in the region of the sacrum. This is sometimes so severe that the patient attributes it to some traumatic cause, as a blow or a fall. Hence it occasionally occurs, that the person upon being received into the hospital is sent to a surgical ward with alleged injury. The eruption of variola soon determines the state of the case. The pain in the sacrum is sometimes attributed to hæmorrhoids, or trouble in the uterus. Again, in other individuals there is pain in the scrobiculus cordis, which would be referred to the solar plexus. Besides these, are observed the most various phenomena, such as headache, vertigo, delirium, insanity, coryza, angina tonsillaris, vomiting, diarrhœa, excessive heat of the body, and in children especially, convulsions, rolling of the eyes, sopor, &c. In one case there was thought to be endocarditis, as auscultation gave a bellows-murmur; but this is a precursory symptom of all exanthemata. Thus these accompanying symptoms are very varied, and of such a nature as to afford no

definite diagnostic data. Their insensibility also has no relation to the severity of the variolous process about to follow. We often see a high fever, with the accompaniments, succeeded by a very slight eruption; and on the other hand, a severe variola occurring where the fever was but slightly marked. In general, we might say that varicella in adults occasions a stronger febrile action than variola vera. The *duration* of the stadium prodromorum also is variable. In children it is generally short, and may be readily overlooked. In adults it is longer. We might consider two or three days its average duration.

2. In the *stadium eruptionis* the special difference consists in the number of the pustules. The following, however, is to be noticed. If the first papules appear on the face, we cannot from that fact determine what form of smallpox is present. Because in all three forms the eruption *may* first appear on the face. But variola vera *always* shows itself here first, and therefore a more severe attack would be expected. If the eruption appears first on any other portion of the body, we have reason to suppose that we shall have to deal with a varicella. With regard to the form of the eruption, it should be said that in the stadium prodromorum the exanthema is frequently preceded by a redness of the skin. (Erythema variolosum or roseola variolosa.) It is important to notice that the presence of *red spots* does *not* indicate the breaking out of a variola, for this is always developed in the form of papules, these being, however, often as small as sudamina. In the great majority of cases there will soon be perceived a slight depression in the middle of the papule, because it is formed around the point of opening of the sebaceous gland and hair follicle. This is a peculiarity which we shall hereafter examine. These papules develop so quickly, from one day to the following, or even in the course of a single day, as soon to be distinguishable from the papules of measles. They will be found enlarging and projecting from the surrounding part—those on the face more developed than the others on the rest of the body.

In that form which we call varicella, this stadium prodromorum does not exist. The fever begins to-day, for instance, and to-morrow the vesicles are already present, especially in children. Even in adults the eruption comes out so fast, that on the second day of sickness the development of the vesicles begins, and the stadium floritionis commences. Yet we know that in varicella, as in variola vera and modificata, the breaking out of the exanthemata begins with the formation of papules, their duration being so short, however, that they are easily overlooked, and the disease is first determined by the subsequent vesicle. In general, it can be said the stadium eruptionis occupies two days in variola, one in modificata, and next to nothing in varicella.

3. *Stadium Floritionis*.—This comes on the fifth day, and lasts six, seven, or even eleven or twelve days. During this time the

papules develop into vesicles, growing in size from the periphery. Their contents increase, are at first clear and pure, and finally, about the eighth day, begin here and there to thicken. It is on the ninth or tenth day that we first perceive a complete opacity, and a yellow color from the change into pus. Thus about a week intervenes from the first appearance of the papules to the time the pustules are fully developed. To remember this we need only recal the analogous changes that occur in vaccination. The vaccinator takes the virus on the eighth day, because the pustule is then most fully developed. The climax of the disease may be stated to occur on the night between the ninth and tenth days, or upon the tenth day. On the tenth day there is generally for the first time a remission of the feverish and accompanying symptoms, often, however, not till the eleventh or twelfth day. From numerous observations on more than six thousand patients, Professor Hebra was convinced that an abatement took place, in the majority of cases, on the tenth day of the disease, which is first known by the refreshing sleep the patient has on the night of that day. The stadium floritionis is, however, not yet ended, but lasts till the formation of a scab commences. The pustules formed by the thickening of the contents of the vesicles, begin at once to dry up. In favorable cases this takes place very quickly, so that often on the tenth, twelfth or thirteenth day the demonstration commences. In variola vera, the change of the vesicle into a pustule is much slower, so that the pustule often remains, as such, three or five days, the desiccation beginning on the face the fifteenth or sixteenth day.

It is quite different with a varicella. Here the stadium floritionis begins on the fourth day of illness. Each vesicle remains as such but one day. On the following day it is already changed into a pustule, which lasts two days, and then becomes a crust. We can, therefore, fix three days as the length of this stadium for varicella. We must notice here one peculiarity which really belongs more to the stadium of decrustation, namely, that whilst a certain number of the pustules are already drying up, fresh ones are repeatedly coming forward.

In variola vera and modificata the above will apply only to the eruption appearing on the face, and not to that on the rest of the body. If, in these two forms, we examine a patient every day, and not only the face but the whole body, we shall see that the papules do not appear simultaneously, and that their development is not equal, so that those on the body are some one or two days behind the others on the face. If, for instance, on the sixth day we find vesicles on the face, we shall still see papules on the body. The same also later, when the face is already scabbing, and the rest of the body, the hands for instance, are covered with pustules or even vesicles. This, therefore, proves that a difference in the time of development does not belong to varicella alone, but also

to variola vera and modificata, with this distinction, however, that in the last two forms the eruption appears and disappears more in anatomical succession, and the pustules keep better pace with each other, whilst in varicella they come out here and there upon the body, without any definite order.

4. The *stadium decrustationis*, as may be inferred from what has been said, does not always begin on the same day. Experience has shown that the course of the disease is more favorable the sooner it commences. When it occurs late, the disease is protracted, and we may have metastases. Much weight is to be laid on this fact in respect to prognosis and treatment, for those cases in which the desiccation commences soon after the tenth day, i. e., where the *stadium decrustationis* is of short duration, end nearly all in recovery. In those in which this stage lasts very long, metastases and a fatal termination are to be feared, even if the patient appears convalescent, if the fever has left him, and the appetite has returned. It is in these cases, and in this stage, that the greatest number of deaths by variola occurs. It is seldom that any ones dies in the *stadium prodromorum*, and in the two following stages but few, and these mostly infants and puerperal women. Most of the fatal issues, on the contrary, happen in the fourth stage, or *stadium decrustationis*. It is in this stage that we find the greatest difference between the several forms of variola. Decrustation occurs quickest in varicella, slower in variola modificata, and slowest in variola vera. Or, in other words, the greater the amount of eruption the slower the decrustation, and the reverse. It begins in varicella on the tenth day, in the other forms later, and with them first on the face, and so successively over the body. In some cases the *stadium decrustationis* lasts a month.

[To be continued.]

CHLOROFORM AND COD-LIVER OIL IN DIPHTHERITIS AND SCARLATINA.

BY E. S. COOPER, M.D., PROF. OF ANATOMY AND SURGERY IN THE MEDICAL DEPARTMENT OF THE UNIVERSITY OF THE PACIFIC.

[Communicated for the Boston Medical and Surgical Journal.]

THE original mortality attending diphtherite, both in this country and Europe, appears to have been but little diminished by any course of treatment in general use. In some regions of country two in three cases terminate fatally, in others four in five, and in some localities of the United States probably there is even still greater fatality.

The first two cases I attended, both in one family, died. They were among the first patients I treated on my arrival in this city, over four years ago. Such was my ill success in attempting to cure these cases for some time afterward, that I thought seriously

of abandoning the treatment of the disease altogether. I had noticed from the commencement of my practice in this disease, that the disposition to slough was always greater after I had used the probang. I attributed this partly to the effects of pressure, or bruising, incidental to the use of the instrument in young children, who are disposed to struggle. I therefore abandoned all applications to the throat, and adopted the following method, which has thus far been successful beyond what my most sanguine hope could have anticipated. Of thirty-one patients, I have lost but one, and in that case the patient had been sick for several days, and died about eight hours after I first saw him.

My treatment is as follows: R. Chloroform, ʒ ij.; ol. jec. aselli, ʒ xii.; spt. terebinth., ʒ ij. M. Signa. Apply freely all over the neck, breast and abdomen, upon flannels covered with oil silk. This I keep on constantly during the continuance of the disease, and for eight or ten days after the patient has sufficiently recovered to walk about. The object of continuance is to prevent relapses, which are very frequent and fatal, without some preventive is used. And this is what is wanted in these cases. Internally, I direct the following to be administered. R. Ext. glycyrrh., ʒ ij.; acacia gum., ʒ i.; antimon. tart., gr. i.; sac. alb., ʒ ij.; aqua, ʒ xvij. M. Signa. Give a wineglassful every two hours to a young child, say two years old, and increase in proportion to age. I have had as much, if not more satisfaction in the results of the treatment of diphtherite on the foregoing plan, than in anything occurring in my professional life besides. I therefore recommend it with confidence to the medical profession. I have tried it with nearly the same success in scarlatina. During the course of treatment I do not give patients a particle of anything else, not a drop of water, nor the least nourishment, save what is in the medicine.

The compound keeps the bowels merely soluble, alleviates the cough, dryness in the throat, and difficulty of swallowing. I have, in some instances, added a grain or two of tartrate of antimony to the compound, and occasionally omit it altogether. I am convinced that certain states of the atmosphere increase the malignancy of diphtherite, and that chloroform and cod-liver oil annul its effects almost entirely. The oil protects the skin, and the chloroform acts probably upon the air-passages, while the turpentine acts as a counter-irritant. I have been surprised, and highly gratified, by noticing the rapidity with which the stoppage of the nostrils and difficulty of breathing is often overcome through this agency, even in advanced stages of the disease.

San Francisco, Cal., December, 1859.

AURAL AFFECTIONS. CASES FROM MY REGISTRY.

BY DR. AARON YOUNG, JR., FARMINGTON, ME.

[Communicated for the Boston Medical and Surgical Journal.]

MESSRS. EDITORS,—I send a few notes of cases of diseases of the ear, selected from my registry, not so much because of their remarkableness, but for the purpose of supplying a modicum of aural literature, a subject which our medical journals seldom touch upon, and yet the profession at large really "know nothing about the diseases of the organ of hearing."

I trust that the opportunities afforded by several years' attention to the subject, induced through a personal interest (for I am myself a sufferer), and enjoying an extensive practice, will be my apology for presuming to diffuse a little information on a subject which has been too long and much neglected by practitioners generally, and, I am sorry to say, but very little understood. But I have no time nor space for useless complainings, and will at once, with your permission, "report occasionally."

No. 181.—Nov. 8th, 1859. A. C., Bowdoinham, aged 55, sallow complexion, and of intemperate habits, applied to me to help an intolerable deafness of only two years' standing. Canals moist, with an ichorous discharge. Right membrane punctured anteriorly about two lines in diameter; left, the same, three lines—both apertures being of an angular shape. The edges were thickened and villous, and the manubrium of the malleus was invisible in both ears. He thinks that "small pieces of bone came out of the left ear." Forced expiration gave free exit to the air, with some gurgling of sound. Had at the first attack a trifling pain, but remembers nothing severe. The bursting of both membranes was simultaneous, with a discharge of bloody matter. Has a great deal of tinnitus, of a rumbling, roaring character. Has long been troubled with nasal catarrh. The habits of the patient not being of a character to attend to any faithful treatment, a weak astringent lotion was prescribed, and small bits of wetted cotton were carefully matted over the apertures. The hearing was surprisingly improved, and after a few days' instruction as to the method of applying the cotton, which he now does himself very readily, his hearing is rendered very good, and little or no difference as to the best ear, thus artificially assisted, is observed. The case is amenable to the healing process, and I trust he may yet yield to the care and attention required for its performance.

No. 199. Flora E., Brunswick, aged 9 years; deaf three years. Hearing distance, watch, six inches either side. Canals—right, normal; left, ceruminous impaction. Membranes—right, dull, with a pinkish hue; malleus prominent; left, after removal of the impaction, vascular. Owing to the tender age of the patient, the condition of the middle ear and Eustachian tube, and whether pain and tinnitus were accompaniments, could not be ascertained.

Restless and sleepless, at night, when reclining on the *right side*, but not fretful. Up to Nov. 28th, 1859, at the time of consultation, had been treated with "all sorts of drops" for the deafness, both ears alike, and without a single examination by the attending physicians. I removed from the left meatus *a pea*, in close proximity to the membrane, and confined by a thin plug of cerumen, yet allowing room enough for the pea to play off and on, according to the position of the body. The hearing on this side was very much improved, and, under the treatment prescribed, has continued to mend. The right ear was undoubtedly injured by the treatment pursued, though the deafness was primarily only in the left, and caused by the pea.

No. 225. Dec. 16th, 1859.—W. W., Rockland, aged 16; very deaf from infancy. When about five weeks old had convulsions, and lay in a state of coma three days. At the end of the third day discharges simultaneously appeared at both ears, and the apparently dying child came to consciousness. These discharges have appeared ever since. The physical signs presented are as follows. Can hear the watch at the right ear in contact; left, none. Both canals contracted and thickened. Right membrane very vascular and villous. Left destroyed, and walls of the tympanum closed to the edges of the narrow ring of the membrane remaining. A shining tubercle presents from the tympanum—through the ring, appearing like a granule of proud flesh, perhaps a polypus. Eustachian tubes free. Has a little pain occasionally, and some tinnitus. The mastoid process, on both sides, depressed. Speech indistinct, many simple words unutterable.

Here is a similar case—same place and date.

No. 226.—Sarah E., aged 13; deaf six years. When 7 years of age had scarlatina, and in the highest of the fever became comatose, and had all the symptoms of cerebral disease. Remained in that condition for *a fortnight!* "Six doctors were employed, and all gave her up to die!" But at the end of two weeks, Nature disclosed the secret, yet a "root and herb doctor," who prescribed at this lucky hour, became really famous. The membranes had burst, and the little patient got about, yet the discharges still remain. Present appearances—walls of the canals covered with a whitish and thick epithelium. Right membrane very fleshy, with a central shining point. Left, very fleshy posteriorly, and a skim-milk like scale anteriorly. Malleus, on either side, invisible. The father of the child says "a dozen or fifteen small bones were discharged from this ear"! The two shown to me ("the rest are lost") consist of the *malleus*, perfect, and the body of the *incus*. The hearing, however, is not lost on this side, in which case the stapes must be *in situ*. Both mastoids are depressed or sunken. The little patient appears bright, and learns fast at school, yet at the commencement of recovery was as simple as an infant, requiring the same care and attention.

Here is another, more interesting still, with which I will close this article, and offer some reflections in another issue of the Journal, as to the cause, effect and treatment.

No. 119. Sept. 19, 1859.—Geo. D., Bangor, aged 9 years. Had scarlatina eighteen months ago, and had a similar turn of coma as in case last mentioned, and revived on the appearance of otorrhœa, but the mastoids, both sides, are extensively involved, bursting through the parietes and maintaining a fistulous discharge—the left twelve months, now healed over, and the right still unhealed—both sunken and depressed very remarkably. The canals are so much contracted and thickened as to preclude any examination of the membrana tympani. An ichorous discharge from both, and at times a thick mucus, offensively foetid. Hearing distance—left ear, watch four inches; right, two inches. Eustachian tubes, free. The patient is active and bright as children usually are at his age.

Rockland, December 20th, 1859.

Reports of Medical Societies.

EXTRACTS FROM THE RECORDS OF THE BOSTON SOCIETY FOR MEDICAL IMPROVEMENT. BY F. E. OLIVER, M.D., SECRETARY.

Nov. 28th.—*Tubal Pregnancy.* Dr. LYMAN reported the following case.

In January, 1859, was called to see Mrs. —, aged 24, married two and one half years. She stated that she had miscarried twice, at six and eight weeks, had always suffered more or less from dysmenorrhœa, sometimes excessively, and that there was no change in this respect since marriage. Had noticed suspicious-looking products in the catamenial discharge on the two preceding occasions; leucorrhœa to a considerable degree, pelvic weight, heat, and tenesmus constant, but much aggravated at the periods. Under treatment these symptoms gradually disappeared, and, March 14th, the report states that "she feels better than for three months."

March 24th, "much better," the periodical discharge which had just terminated being entirely "painless."

August 1st.—Found her suffering as much as ever from dysmenorrhœa, having neglected treatment, and been otherwise imprudent. Directed that three grains of Plummer's pill should be taken each night, and two or three leeches applied to each groin two or three days before the next period, after which to remain in bed until the flow was fully established. These directions were carefully followed, but the catamenia did not again appear; conception had taken place.

Sept. 3d.—Since the last report, the patient has been in ordinary health, slight morning sickness only; nothing worthy of note, except that once or twice she had been troubled with slight pain and uneasiness in the lower part of the abdomen, as though menses were about to appear, which her previous experience made her apprehensive might result in another miscarriage. An opiate, however, on such occasions, produced immediate and entire relief.

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Sunday, Oct. 16th.—Was sent for in haste; found her in bed, much exhausted with *spasmodic* pain, the intervals of which were well marked, and free from suffering; no vaginal discharge, but *excessive* pain and scalding in micturition, the vesical tenesmus being most severe with the last few drops; urine very abundant and pale, litmus reddened by it; no pain in region of kidneys or down the thighs. Notwithstanding the free secretion, the diagnosis was strangury from some unknown cause, and under the use of warm fomentations, demulcent drinks, and an opiate, the difficulty soon yielded, and the following day she was in her usual health.

Wednesday Oct 26th.—On rising from bed at 7 o'clock, she expressed herself as feeling unusually well. Soon after, while stooping to arrange her stockings, sudden *diffused* pain was felt in the lower part of the abdomen, followed by faintness, nausea and vomiting of light, thin, bilious fluid. These symptoms rapidly increased in severity until I saw her at 9½. She was then in a state of extreme prostration, no radial pulse perceptible, surface dry, cold and blanched. The pain came severely in decided paroxysms, and she begged for relief from what she supposed to be bilious colic, a complaint to which she had always been more or less subject. A very short observation, however, made it evident that so great collapse was inconsistent with such a diagnosis, and her friends were warned of the existence of some fatal rupture internally, with hæmorrhage, which could only be accounted for by the extra-uterine development of the child. Ether was given to allay the distress, and at half past 10 she died. (For details of the autopsy, see Case X., page 464.)

Of the several forms of extra-uterine pregnancy, the tubal, tubular, or Fallopian, is said by authors to be the most frequent; but after some research I am unable to find, including my own and the case of Dr. Storer (occurring the past week, and reported to the Society this evening), more than eleven which have occurred in this vicinity. For convenience of reference hereafter, I have given below a condensed sketch of the most important features of each case, from the Records of the Society, the note books of Dr. J. B. S. Jackson, and personal inquiries of some of the gentlemen in whose practice the cases occurred. Three other cases have, it is said, occurred in this city, but I can get no such authentic details of them as would justify their insertion.

A very interesting case of interstitial pregnancy, reported by Dr. Stedman, may be found in the second Volume of the Society's Records, page 270. Of the remaining varieties in which the ovum was developed in the abdominal cavity, never having entered the Fallopian tube, many cases are reported. These, as is well known, are not necessarily fatal, the foetal bones being often discharged, after the lapse of years, through the rectum, vagina, bladder, or abdominal parietes. Of these it is not impossible that some may have been tubal, the development of the foetus being arrested by its death before attaining such growth as to rupture the tube, and remaining encysted for an indefinite period; or by suppurative inflammation and adhesion forming a communication with some neighboring outlet, either with or without operative interference. The general opinion, that this variety of extra-uterine pregnancy results fatally by rupture of the tube about the third month, is probably correct in the majority of cases; but that the tube, delicate as it is, is capable of distension, without rupture,

even to such an extent as to contain a full-grown fœtus, is tolerably certain.

"De Häen speaks of a hypertrophied tube, which weighed alone seven pounds, and contained twenty-three pints of fluid."—(Boivin and Duges, London, 1834, p. 501.) The same authors quote another case from Frank, in which after death (from phthisis) "thirty-one pints of aqueous and gelatinous matter were found in the left Fallopian tube." In the Cyclopædia of Practical Medicine, Vol. IV., p. 599, Saxtorph's case is mentioned, in which the patient went to the end of the ninth month. In Dr. Perry's case also (see below, No. V.), the tube was not ruptured, though the patient was between six and seven months pregnant, the fœtus weighing two pounds and measuring 13½ inches. Andral mentions a case (not pregnant) in which abscess of the Fallopian tube opened into the rectum. (*Anatomie Pathol.*, t. ii., p. 700.) In Vol. LV. of the Boston Med. and Surg. Journal, there is a case from the American Magazine, a journal of the last century, reported by Dr. Nathan Hale, of Newbury. The patient died of phthisis, in July, 1745-6, having carried the tumor some fourteen or fifteen years, and bearing six children during that time. Soon after the birth of the last, and four months before death, a discharge of matter took place near the umbilicus, and a month before death the bones of an entire fœtal skeleton, of full size, were removed through the opening! The autopsy showed that the right Fallopian tube had contained the fœtus.

As to the symptoms of tubal pregnancy, there seem to be none which can be considered as pathognomonic. Of the cases reported here, two complained, for some time previous to the fatal attack, of constipation, and severe pain in defecation. Painful micturition, amounting to strangury, was noticed in two of the cases, in one two months, the other ten days before death; and in two others, attacks of acute pain and syncope occurred about ten days before death. In four of the cases there had been more or less hæmorrhage during the pregnancy, supposed to be catamenial. Ten of the eleven cases occurred in married women, of whom four had previously borne children. The age averages 26 years. The right tube was the seat of pregnancy in eight, the left in three cases. Of the ten cases in which mention is made of the decidua, four were found to have it well marked, thus confirming the statement of Cazeaux and Lee in opposition to that of Velpeau.

To complete the list of cases of extra-uterine pregnancy in possession of the Society, it may be well to refer here to three of the abdominal variety; the first presented by Dr. Miller, of Franklin, in which the tumor was carried seven years, the woman in the mean time bearing three living children. The fœtus, weighing 4½ pounds, was finally extracted through an incision below the umbilicus. The second, a patient of Dr. Bossuet. In this case, at the end of three years, the fœtus found its way into the bladder. A communication was afterward formed between the bladder and rectum, so that the urine and fæces would pass either way. Finally, nine years from the date of pregnancy, Dr. B., by the operation for lithotomy, removed from the bladder 146 bones of a seven months' fœtus! See Catalogue of the Cabinet of the Boston Society for Medical Improvement, pp. 225-226. The third case is reported by Dr. Putnam. In this case the patient died apparently of exhaustion, about the fourth month. The placenta,

which was unusually large, was found "attached to the region of the sacrum and rectum." In this case, also, severe pain at every fecal evacuation was a prominent symptom.—*Records of Boston Society for Medical Improvement*, Vol. I., p. 337.

I.—Case of Dr. SHURTLEFF. 1840. (From *Records of Boston Society for Medical Improvement*, Vol. III., p. 104, and from note book of Dr. J. B. S. Jackson.)

Age 32 (Dr. S. says married), two living children. Probably in third month of pregnancy. Two months before death, attacked with pain in bowels, strangury, and uterine hæmorrhage, which continued more or less during life, with frequent syncope. A week before death had peritonitis; so far relieved of this as to be about, the last three days. Constipation, and extreme pain when at stool; not stated how long this latter symptom prevailed. Lived $3\frac{1}{2}$ hours; two quarts of blood in abdomen, from rupture of right tube; uterus $4\frac{1}{2}$ inches long; no decidua; fœtus $4\frac{1}{2}$ inches long. Traces of peritonitis, as lymph, &c., about parts. Corpus luteum, 3 by 4 lines.

II.—Case of Dr. FLINT. June, 1842. (From *Records of Society*, Vol. III., p. 104, and Notes of Dr. Jackson.)

Age (Dr. F. states about 27); had had three children; period of pregnancy not stated (probably six weeks); no previous hæmorrhage, or other unusual symptoms; lived twenty-four hours. Right Fallopian tube distended near uterine extremity to size of "last joint of finger," and lacerated two thirds of an inch. Ovum, amnion and chorion well marked; fœtus not found; three quarts of blood in abdomen. Uterus three inches long; no decidua. Corpus luteum in right ovary, well marked, seven by five lines. Case seen by two other gentlemen before death; considered by one to be aneurism, by the other peritonitis.

III.—Case of Dr. BUCK. July, 1842. (From *Records of Society*, Vol. III., p. 104, and Notes of Dr. JACKSON.)

Age 24; married in April; first pregnancy, probably two months. Had slight "show" for a few days, which ceased twenty-four hours before death. Had catamenia in April; died July 10th. After brutal treatment by husband, thirty-six hours before death, symptoms of internal hæmorrhage appeared. Lived 36 hours. Five pints of blood in abdomen; left Fallopian tube lacerated for extent of two lines; ovum not escaped. Uterus $3\frac{1}{2}$ inches long; no decidua. Fœtus, 3-8th inch. Corpus luteum in left ovary. Patient seen by Dr. BIGELOW, and rupture diagnosed before death.

IV.—Case of Dr. FISHER. No date. (From *Catalogue of Cabinet and Records of Society*, Vol. III., p. 104.)

Age 18, married ten weeks; supposed two months pregnant. Had frequent and profuse hæmorrhage since a fortnight after marriage, with slight pain and tenderness above right groin, and sense of fullness in the abdomen. Lived twenty hours after attack. Three quarts blood in peritoneal cavity. Right Fallopian tube ruptured. Uterus $3\frac{1}{2}$ inches long; no decidua. Fœtus $\frac{3}{4}$ inch long, not escaped from tube. No mention of corpus luteum.

V.—Case of Dr. PERRY. May, 1843. (From *Records of Society*, Vol. III., p. 105, and Notes of Dr. JACKSON.)

Age 34; married eleven years; first pregnancy, and supposed to be between six and seven months. Had suffered during married life from dysmenorrhœa; had never miscarried. Since beginning of pregnancy

had been unable to stand erect from soreness in hypogastrium. Dysuria not more than usual in early months; somewhat constipated, but no pain in defecation; thought she perceived motions of child. These ceased six weeks before death, when she was attacked with purpura, after which uterine hæmorrhage, but not to a large amount, was frequent. Two weeks before death had copious epistaxis for three days, and again during the last week. After death, the right Fallopian tube was found dilated into a large cyst, filled with a bloody fluid, and containing also the fœtus, $13\frac{1}{2}$ inches long, and weighing two pounds. The bloody fluid had evidently, it is stated, been effused into the sac long before death. No rupture of the tube, and no hæmorrhage into the peritoneal cavity. Cyst filled cavity of pelvis, and extended into hypogastrium. Uterus four inches long; no decidua. No trace of corpus luteum in right ovary, though thoroughly examined; left ovary not found.

VI.—Case of Dr. OAKES. May, 1854. (From *Records of Society*, Vol. II., p. 117.)

Age 25, unmarried; three months pregnant; no previous hæmorrhage. Had nausea, vomiting and pain in the uterine region for ten days previous to the fatal attack, which finally came on suddenly, with pain, vomiting and collapse. Lived four and a half hours. Fourteen pints of blood in peritoneal cavity. Ovum contained in left Fallopian tube, which was dilated to size of fist in its middle portion, but the seat of perforation could not be found. Dropsy of right Fallopian tube, which was distended to size of fist. Uterus four and a quarter inches long; decidua well developed. Evidences of attempt at abortion. Corpus luteum in left ovary, 1 by $\frac{1}{2}$ inch.

VII.—Case of Dr. TEBBETTS. July, 1855. (From *Records of Society*, Vol. II., p. 257.)

Age 25, married; probably third month of pregnancy; not stated whether she was ever before pregnant. No previous hæmorrhage. Confessed to having attempted abortion by medicine. Lived 7 hours. Six to eight pints of blood in abdomen. Right Fallopian tube, near distal extremity, distended to size of an English walnut and lacerated; the ovum had not escaped. Another fœtus found in uterus about 3 inches long. Two well-marked corpora lutea in right ovary.

VIII.—Case of Dr. BROOKS. February, 1857. (From *Records of Society*, Vol. III., p. 102.)

Age 25, married; one child two years old. Ten weeks pregnant. No previous hæmorrhages; complained of pain in pelvic region for four or five weeks preceding, when evacuating bowels. Lived twenty-eight hours. Peritoneal cavity filled with blood. The sac near the distal extremity of the right tube, lay by the side of, and over the rectum, and was extensively lacerated; fœtus not escaped. Uterus $3\frac{1}{2}$ inches long; decidua well marked. No trace of corpus luteum in either ovary, though carefully examined.

IX.—Case of Dr. HOOKER. November, 1857. (From *Records of Society*, Vol. III., p. 183.)

Age 25, married about five months; seven weeks pregnant; no previous hæmorrhage. Eight days before fatal attack, seized with sudden acute pain and syncope; relieved by opiates, and in two or three days able to be about the house, though with some uneasiness remaining in left hypochondrium. At time of fatal attack, "felt something give way in bowels, just below navel," with acute distressing pain

and faintness. Lived twenty-four hours. Three quarts of blood in abdomen. Tumor of left Fallopian tube, $1\frac{1}{2}$ inch long $\frac{3}{4}$ inch broad. No embryo found, but placenta distinctly recognized. Decidua not mentioned, but a recent examination of the specimen with Dr. JACKSON, shows it to be well marked. Corpus luteum in left ovary, and both ovaries contained hydatids.

X.—Case of Dr. LYMAN. October, 1859. (Not before published. Autopsy from Notes of Dr. ELLIS.)

Age 24, married two and a half years; miscarried twice, at six and eight weeks. Had always suffered from dysmenorrhœa. Ten weeks pregnant. Slight pains and uneasiness in pelvic region during that time. No previous hæmorrhage. Ten days before death, had a very severe attack of pain in pubic region, like strangury, which was relieved by an opiate. Fatal attack came on with sudden diffused pain in hypogastric region, spasmodic in its character, with distressing rather than painful intervals. The rapid collapse led to a correct diagnosis before death. Lived three and a half hours. Two quarts of blood in abdomen. Right Fallopian tube dilated from its uterine termination outward, into a sac two inches in diameter, the sulcus separating it from uterus being strongly marked, though shallow. From sac to fimbriated extremity, three and a half inches. Rent in upper anterior portion of sac, one and a half inch long. Fœtus, 3 inches in length, lay in pelvic cavity, length from vertex to umbilicus 2 inches. Cord unbroken. Uterus much softened, length 3.5-8 inches; breadth at widest part, $2\frac{1}{4}$ inches. Vascularity increased, vascularity of sac very marked; decidua perfect. Fine corpus luteum in right ovary, $\frac{3}{4}$ of an inch in diameter. Cyst, size of a pea, upon the left ovary, and within, traces of an old corpus luteum.

XI.—Case of Dr. STORER. November, 1859. (Not before published. Autopsy from Notes of Dr. ELLIS.)

Age 27, married six years; two children, last one $3\frac{1}{2}$ years of age. About ten weeks pregnant. Between four and five weeks before death, discharge appeared from uterus, supposed to be catamenia; continued for three weeks, ceased and re-appeared a day or two before death. Previous to pregnancy had suffered much from uterine derangement. Was attacked about breakfast-time with agonizing pain, "as if she was going to have a child." Failed gradually, with usual symptoms of internal hemorrhage. Lesion correctly diagnosed. Lived six hours. Three pints of blood in abdomen. Sac in right tube, oval, and extending through its outer half; $1\frac{1}{2}$ inch long, and 15-16ths of an inch broad. Tube pervious for some distance between sac and uterus. Rent irregular, one third of an inch long, and no part of ovum escaped. The left tube apparently ended in a cul de sac, but on pressure a reddish secretion issued from two points. In left ovary, several Graafian vesicles, and remains of two old corpora lutea; in centre of largest one, a little blood. In right ovary, a beautiful specimen of corpus luteum, half an inch in diameter, thickness of capsule from two to three sixteenths of an inch in diameter. A cavity in centre occupied the remainder, and was lined by a strong, well-marked pearly membrane, with blood effused beneath half of it. Uterus, $3\frac{1}{2}$ inches long, and no sign of decidua; the contrast in this respect with the preceding case being very striking as seen together.

 THE BOSTON MEDICAL AND SURGICAL JOURNAL.

 BOSTON, JANUARY 5, 1880.

STAMMERING: METHODS OF CURE.—We entered somewhat into detail upon this subject last week, in connection with a notice of a pamphlet devoted to the consideration of the Cause and Cure of the infirmity; and we intimated an intention of again referring to the matter.

The expression "attacking the sound," made use of by Rev. Mr. Cazalet, the author of the above-mentioned *brochure*, to convey the idea of his method of cure, is not easy to understand merely in words. It would be best comprehended by seeing the method put in action—and this he himself admits. We endeavored in our last issue to give such extracts from Mr. Cazalet's work as would illustrate—so far as description alone can do—the process referred to by the phrase "attacking the sound." We will once more cite the author's explanatory remarks. "The first point to be considered is the method of *attacking the sound*, that is to say, of placing the articulating organs in such a position as to modify the sound in the manner required." * * * "To understand articulation rightly, it will be necessary to explain the organic formation of the letters of the alphabet. These are usually divided into mutes, liquids, and vowels. As the lips, tongue, and teeth are the only organs employed in the formation of letters, it is evident that the combinations cannot be very numerous. The principal cause of difference or distinction is to be found in what may be called the different pressures of the organs for the various letters. Thus the B is a letter requiring hard pressure, the outer lips are pressed forcibly together, and the attack of the open sound is made simultaneous with the vocalization of the breath. This rule is invariable, differing only in the force required for the letter. The P, on the contrary, although produced by precisely the same action of the outer lips, is made by a gentle pressure only, and this distinction should be preserved throughout all the letters of the alphabet made by different pressures." We have not space to quote more upon this portion of the subject. The author has entered very fully into the *management of the voice*, in another work—as we mentioned in last week's JOURNAL. His directions seem to us admirably suited to the requirements of all persons obliged to speak in public.

Under the head of "General Observations," Mr. Cazalet refers to the necessity the stammerer is under in order to advance toward a cure—"of restraining his own efforts." The abandonment of force, in endeavoring to produce the articulate sound desired, is one great element of success. The stammerer cannot believe, at first, that the less effort he makes, the more likely he is to enunciate clearly. "Even when many errors have been removed, the habit of forcing will often recur at intervals, until entire control has been acquired over the organs of speech."

The quality of the sound to be produced, is to be particularly attended to; and the stammerer should seek to make it "clear" and "vibrative" in character—this result being the test of right action of

the organs in articulating. "The voice," says Mr. Cazalet, "should, in a manner, be played upon like a wind-instrument, the articulating organs acting upon the voice as the fingers upon the holes. In attacking the sound, attention should always be paid to the pitch of tone; by this alone, relief will often be obtained, and assistance afforded, more especially when the stammerer is called upon to keep up a conversation, or to speak or answer suddenly."

Allusion is also made by the writer to the powerful influence of well-regulated *respiration*, in the attempt to remedy stammering. Stammerers, as a rule, "seldom make any free use of the lungs, and the power of proper inflation being thus, to a certain extent, lost from want of practice, indistinctness of speech necessarily arises." But all *extremes* should be avoided. Many empirical pretenders to success in curing stammering, advocate that excessive straining and effort of the breath which has been judiciously condemned by Mr. Cazalet. He states that he had, while writing his pamphlet, an instance under his observation "of an unhappy victim of such a system, who had actually broken a bloodvessel, and was very near falling a sacrifice to his own terrific exertions." A proper use and inflation of the lungs is, on the other hand, strongly to be encouraged.

The neglect of the medical profession to follow out, more perseveringly, efforts to cure stammering; and the unwillingness manifested at attempting such a cure, have naturally enough left the sufferers an easy prey to designing and ignorant pretenders, who pocket the money of their dupes, but fail to restore them the use of the organs of speech. Such persons sometimes announce that they cure stammering by *electricity*, and by that alone. Advertisements to this effect every now and then appear in the newspapers of the day, and deceive scores of the credulous multitude. Scientific men—both elocutionists and physicians—should endeavor to rescue the management of these cases from the abuse which too frequently surrounds it, both in this and in every community.

No stammerer should be allowed by his guardians and friends to neglect attempts at cure; for, aside from the painful nature of the infirmity, both for the individual affected and for those who witness his hideous grimaces and distressing efforts, the mind is likely to become affected secondarily. "Mental hesitation may, and often does, follow as a consequence of defective utterance." * * * "There is a strict analogy between the organic and mental condition. And though the defect of stammering is, and ought to be, treated as local, there are circumstances attending it which must be looked upon as general."

The last remark leads us, in closing this article, to refer to the powerful influence exercised over the stammer by teaching him to *enunciate rhythmically*. This is a general, rather than a local action, and to this method we alluded at the end of our first article on this subject. Whilst in the Dispensary consulting-room of Mr. Yearsley—the well-known aurist of London—a few weeks since, a boy of some ten years, who stammered fearfully, was presented to Mr. Y. for advice—having come in by some chance amongst the out-patients, possibly on account of this surgeon's reputation in what he has termed throat-deafness and other kindred affections. We never met with a worse stammerer, nor did we ever witness the defect disappear more quickly and entirely—at least for the time he was under training. Having been instructed

how to speak, i. e., in a sing-song, cadenced style, the little patient talked as smoothly and freely as any one, much to the surprise of his mother and himself. This method, as we have previously said, has been tried heretofore, with more or less lasting curative results. Is it not probable—nay certain—that the relapses which are chronicled as following its apparent success, are owing to patients not being persevered with by their medical attendants, or by others who undertake to manage such cases? If this means, so completely successful at first, be resolutely followed until the *habit* of stuttering be overcome, the triumph is certain. Has it ever, yet, been long enough tried?

LECTURES ON SANITARY SCIENCE.—We wish to call attention to a proposal of Mr. E. Y. ROBBINS to deliver a short course of lectures on the subject of sanitary science in this city. The first lecture has already been given, and will be repeated, if a sufficient number of tickets can be sold. Mr. ROBBINS is recommended in the highest terms by a committee of influential citizens who are competent judges of his abilities to do justice to this important subject. At no time could public attention be more appropriately awakened to the necessity of sanitary measures than at the present, while a loathsome disease is prevalent among us, which might have been wholly prevented by the adoption of the most simple means. The employment of vaccination as a preventive of smallpox is, however, but one of the many blessings which a knowledge of sanitary science might secure to us, and a lamentable ignorance of the subject still prevails among us. It is quite time that these important facts should be generally known.

CONVENTION OF MEDICAL TEACHERS.—We desire to correct a statement which we inadvertently made in a late number, respecting the Convention of Medical Teachers to be held at New Haven on the day before the next annual meeting of the American Medical Association. In the number for December 13th (page 404) we said that the Convention would meet at New York on June 1st. It is the meeting of the *Committee of Conference*, appointed by the Convention and by the Association, which will be held in New York, June 1st, at the College of Physicians and Surgeons, corner of East 23d street and 4th Avenue. The Convention of Teachers will meet on the following Monday, June 4th, at New Haven.

HEALTH OF THE CITY.—Consumption, smallpox and scarlatina were the chief fatal diseases of the past week, in the proportions respectively of 22, 10 and 6. Of the first named, 8 males and 14 females died. Of smallpox, 6 males (2 children and 4 adults) and 4 females, all children, died. Two of the deaths by old age were of males, aged 85 and 84, and one a female, aged 89. Of the whole number of deaths, 37 were of subjects under 5 years of age, and 25 between 20 and 40. The causes of death were reported by physicians in 19 cases only out of the 87. The total number of deaths for the corresponding week of 1858 was 86, of which 20 were from consumption, 7 from pneumonia, 0 from smallpox, 4 from scarlatina, 3 from old age.

MASTICH IN INCONTINENCE OF URINE.—Dr. DEBOUT strongly recommends the employment of the tears of gum mastich in the incontinence of urine of children, in the dose of one drachm night and morn-

ing. It may be made into bolus with syrup, or divided into pills. The cure is usually effected in four days, but if the remedy is not successful in eight days, it is useless to continue it longer. It has proved successful in more than two thirds of the cases in which Dr. DUBOIS has employed it.—*Union Médicale*.

CHLORATE OF POTASH. *Messrs. Editors,*—In the recent number of your JOURNAL, dated December 8, 1859, I notice that you publish the statement of Dr. Henry Osborn, that he has discovered *toxic* properties in the chlorate of potash. Allow me to call your attention to a reply to this, published in the *New York Medical Press* of Nov. 19th, 1859, in which I think I have demonstrated that the chlorate of potash has no such property. I refer to cases in my practice in which I have given from half an ounce to an ounce daily, with the happiest effect, and no unpleasant symptom; and immediately upon reading the views of Dr. Osborn, as published in the *Philadelphia Medical and Surgical Reporter*, I dissolved half an ounce of the chlorate of potash in a tumblerful of hot water, and drank it all at once. I described the effects produced, which were not of the least injurious character, and certainly not *toxic* in the slightest degree. The publication of Dr. Osborn's statement, that he experienced "*pain in the head, symptoms of congestion of the brain, slight paralysis of one side of the face, and loss of taste,*" (!) all from taking "at intervals of some weeks, doses of from five to fifteen grains of the chlorate" (!) is calculated to do much harm with those who are willing to believe such an improbable story.

I shall presently report some cases in which I have administered it in large doses (half an ounce daily) for the arrest of tubercular disease, with perfect success. Several have recovered on its use with surprising rapidity, after the failure of ordinary tonics, cod-liver oil, hypophosphates, &c. The cases verify the prediction I made on theoretical views, in a paper on the properties of chlorate of potash, published in the *New York Journal of Medicine* of July last. I take the liberty of sending you a copy of the same, as it may have escaped your notice. You are at liberty to use this in any way you think proper; but my object in writing to you is simply to call your attention to my notice of the alleged *toxic* properties of the chlorate of potash, published in the *New York Medical Press*.

Very respectfully,

Yours, &c.,

Davenport, Iowa, December 17, 1859.

E. J. FOUNTAIN.

AN ABBATOIR, such as exists in the vicinity of Paris, is proposed to be established adjoining one of the large drove-yards in the suburbs of Philadelphia. Instead of driving cattle through the densely populated portions of the city to private slaughter houses, which is attended with inconvenience and danger, they can be slaughtered and dressed, and brought, during the night, to the shambles. There would be some hygienic advantage in removing many nuisances which necessarily attend the slaughtering of animals in various localities, as it is now done, and greater economy, and the useful preservation of the offal, could be better effected, if the work of the butchers were confined to one locality.—*Philadelphia Medical and Surgical Reporter*.

ERRATA.—Page 370, line 16, for "explanations" read *explorations*; line 40, for "larger" read *longer*.

Books and Pamphlets Received.—Transactions of the American Medical Association, Vol. XII.—Sketches of Rhode Island Physicians, deceased prior to 1850. By Usher Parsons, M.D.—Selections from a Report on Ovariectomy. By J. Taylor Bradford, M.D., Augusta, Ky.

Deaths in Boston for the week ending Saturday noon, December 31st, 57. Males, 45—Females, 43.—Apoplexy, 1—bronchitis, 3—inflammation of the brain, 1—congestion of the brain, 1—cancer, 1—consumption, 22—convulsions, 3—croup, 4—cirrhosis, 1—debility, 2—puerperal disease, 2—dropsy in the head, 2—drowned, 1—scarlet fever, 6—typhoid fever, 2—gastritis, 1—homicide, 2—disease of the heart, 2—inflammation of the lungs, 2—marasmus, 1—old age, 3—pericarditis, 1—premature birth, 1—scalded, 2—smallpox, 10—sore throat, 1—unknown, 9—whooping cough, 1.
Under 5 years, 37—between 5 and 20 years, 7—between 20 and 40 years, 25—between 40 and 60 years, 13—above 60 years, 5. Born in the United States, 60—Ireland, 23—other places, 5.